Washington State Health Care Authority
Public Employees Benefits Board

Adding a Spouse or Same-Sex Domestic Partner to Your PEBB Coverage

Complete and return the form in this packet if you want to:

- Add a spouse to your Public Employees Benefits Board (PEBB) coverage, or
- Add a qualified same-sex domestic partner to your PEBB coverage.

Adding a Spouse

Remove the form from this packet.

Step One:

- Complete Section 1.

Step Two:

- Read and complete Section 3.

Step Three:

- **Employees**: Return the form to your personnel, payroll, or benefits office.
- **All others**: Return the form to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Adding a Same-Sex Domestic Partner

Remove the form from this packet.

Step One:

- Review and complete Section 2; be sure you meet the 10 criteria.
- Read and complete Section 3.

Step Two (for **active employees** and **Medicare retirees** only):

- Review the *Declaration of Tax Status* on the back of the form.
- Determine whether your same-sex domestic partner fulfills the three requirements listed for Internal Revenue Code (IRC) Section 152 tax eligibility. **Your same-sex domestic partner does not need to qualify as an IRC Section 152 dependent to qualify for PEBB coverage.**
- Print your names at the top of the *Declaration of Tax Status* form.
- If you are unsure whether your same-sex domestic partner qualifies as an IRC Section 152 dependent, you may confirm eligibility by using the IRC *Worksheet for Determining Dependent Status* form. Go to Step Three.
- If your same-sex domestic partner qualifies as an IRC Section 152 dependent, go to Step Four.

Step Three:

- If completing the optional *Worksheet for Determining Dependent Status*, you and your same-sex domestic partner will need to know your:
  - Gross monthly income
  - Mortgage/rental payment
  - Monthly expenses for items such as food, utilities, repairs, clothing, education, medical, travel, etc.
- Keep the worksheet for your personal tax records. You do not need to return the worksheet with the other forms.

Step Four:

- Sign, date, and print your social security number on the *Declaration of Tax Status* form.
- **Employees**: Return the forms to your personnel, payroll, or benefits office.
- **All others**: Return the forms to the Washington State Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684.

Important! Be sure to also submit a completed PEBB enrollment form.

Declaration of Marriage or Same-Sex Domestic Partnership

Washington State Health Care Authority
Public Employees Benefits Board

Section 1: Spouse

I, _____ , certify that _____
Print Subscriber's Name — Print Spouse's Name

and I were legally married on _____ / _____ / _____ .
month / day / year

Section 2: Same-sex domestic partner

I, _____ certify that _____
Print Subscriber's Name — Print Same-Sex Domestic Partner's Name

and I established a same-sex domestic partnership beginning _____ / _____ / _____ and we meet the
month / day / year

following criteria for a same-sex domestic partnership:

1. We have been same-sex domestic partners continuously for a minimum of six months.
2. We share the same regular and permanent residence.
3. We have a close personal relationship in lieu of a lawful marriage.
4. We have agreed to be jointly responsible for basic living expenses[1], as defined below, incurred during the domestic partnership.
5. We are not married to anyone.
6. We are each eighteen (18) years of age or older.
7. We are not related by blood as close as would bar marriage.
8. We were mentally competent to consent to a contract when the domestic partnership began.
9. We are each other's sole domestic partner and are responsible for each other's common welfare.
10. We are same-sex partners who are barred from a lawful marriage.

[1] "Basic living expenses" means the cost of basic food, shelter, and any other expenses of the common household. You and your same-sex domestic partner need not contribute equally or jointly to the payment of these expenses as long as it is agreed that both are responsible for them. If requested, you should be able to provide at least three of the following as verification of your joint responsibility (information should be dated to confirm eligibility at time of enrollment):

- Joint mortgage or lease.
- Designation of the same-sex domestic partner as primary beneficiary for a life insurance or a retirement contract.
- Designation of the same-sex domestic partner as primary beneficiary in the employee/covered member's will.
- Durable power of attorney for health care or financial management.
- Joint ownership of a motor vehicle, a joint checking account, or a joint credit account.
- A relationship or cohabitation contract which obligates each of the parties to provide support.

Subscribers are advised to consult an attorney regarding the possibility that the filing of this declaration may have other legal and/or financial consequences, including the fact that it may, in the event of the termination of the domestic partnership, be regarded as a factor leading a court to treat the relationship as the equivalent of marriage for the purposes of establishing and dividing community property, assigning community debt, and for the payment of support.

Section 3: Signature (required)

It is understood that:

- This declaration shall be terminated upon death of the spouse or same-sex domestic partner or by change of circumstance attested to in this declaration.
- Employees will notify their personnel, payroll, or benefits office and retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA)/self-pay members will notify the Health Care Authority at 1-800-200-1004 if the marriage has dissolved or the domestic partnership no longer meets all of the criteria attested to in this declaration within 60 days of a change.

We declare, under penalty of perjury, that the foregoing information provided by us is true and correct and that all provisions of this statement have been met. Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Subscriber's Signature	Social Security Number	Date
	- -	
Spouse or Same-Sex Domestic Partner's Signature	Social Security Number	Date
	- -	

Agency use only	Agency	Subagency

Declaration of Tax Status

I, _____ , have completed a *Declaration of Marriage orSame-Sex Domestic Partnership*
Print Subscriber's Name

form and have sworn that _____ is my same-sex domestic partner.
Print Same-Sex Domestic Partner's Name

I understand that my employer has a legitimate need to know the federal income tax status of my relationship. I understand that a same-sex domestic partner is considered an Internal Revenue Code (IRC) Section 152 dependent **only if each** of the following requirements is met (does **not** affect your same-sex domestic partner's eligibility for PEBB coverage):

1. The same-sex domestic partner and I live together (share our principal abode) for the full taxable year, except for temporary absences for reasons such as vacation, military service, or education. In other words, my same-sex domestic partner and I must live together from January 1 through December 31.
2. The same-sex domestic partner is a citizen or resident of the United States.
3. The same-sex domestic partner receives more than half of his or her support from me. The rules for determining support are complicated and are more involved than just determining who is the "primary breadwinner." Enclosed is a worksheet similar to one the Internal Revenue Service (IRS) includes in its Publication 17 that you can use to determine whether you provide more than half of your same-sex domestic partner's support.

Please Note:
Even if the above requirements are met, an individual cannot be considered an IRC Section 152 dependent if the relationship violates local law.

Check one of the following boxes; **coverage is only available** if you check a box. Since the above is a summary of complex tax rules, we recommend you consult with your tax advisor regarding your specific circumstances. I declare that:

❑ **Yes**, my same-sex domestic partner **is** my Internal Revenue Code Section 152 dependent.

❑ **No**, my same-sex domestic partner is **not** my Internal Revenue Code Section 152 dependent. As a result, premium contributions for my same-sex domestic partner cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

❑ **Yes**, my same-sex domestic partner's child(ren) as named below **are** my Internal Revenue Code Section 152 dependent(s).

Child(ren)'s name(s) _____

❑ **No**, my same-sex domestic partner's child(ren) as named below **are not** my Internal Revenue Code Section 152 dependent(s). As a result, premium contributions for my same-sex domestic partner's eligible family members cannot be taken on a pre-tax basis (under IRC Section 125), and the fair market value of the benefits my employer provides for my partner will be added to my taxable income.

Child(ren)'s name(s) _____

By signing below, you are stating that:

I understand that this information will be held confidential and will be subject to disclosure only upon my express written authorization or if otherwise required by law. I understand that this declaration of responsibility may have legal implications under federal and/or state law. I understand that a civil action may be brought against me for any losses, including reasonable attorney's fees, because of a false statement contained in this *Declaration of Tax Status*. I also certify under penalty of perjury, under the laws of the state of Washington, that the foregoing is true and correct.

I, the undersigned subscriber, understand that willful falsification of information on this declaration may lead to disciplinary action, up to and including discharge from employment and/or disenrollment from PEBB coverage. I agree to notify my personnel, payroll, or benefits office or the Health Care Authority at 1-800-200-1004 if there is any change in the circumstances attested to in this declaration within 60 days of the change. *I am aware that any change in my family tax status may directly impact the calculation of my taxable income.*

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

_____	_____ - _____ - _____	_____
Subscriber's Signature	Social Security Number	Date

Worksheet for Determining Dependent Status

(Worksheet modeled after the IRC worksheet in Publication 17)

Do **not** return this form; keep for your own tax records.

Important!

You can use this worksheet to determine whether your same-sex domestic partner and/or his or her child(ren) qualify as dependents under Internal Revenue Code (IRC) Section 152 (in general, he or she must receive more than half of his or her support from you).

Income

1. Did the same-sex domestic partner you supported receive any income such as wages, interest dividends, pensions, rents, social security, or welfare?
   - ❑ Yes (Answer questions 2, 3, 4, and 5.)
   - ❑ No (Skip to question 6.)
2. Total annual income received $ _____
3. Amount of income used for your same-sex domestic partner's support $ _____
4. Amount of income used for purposes other than support $ _____
5. Amount of income either saved or not used for lines 3 or 4 $ _____

The total of lines 3, 4, and 5 should equal line 2.

Yearly household expenses where you and your same-sex domestic partner lived

6. Lodging (*Complete either a or b):*
   a. Rent paid $ _____
   b. If not rented, show fair rental value of your home $ _____
   If your same-sex domestic partner owned the home, include this amount on Line 20.
7. Food $ _____
8. Utilities (heat, light, water, etc. not included in line 6a or 6b) $ _____
9. Repairs that were not included in line 6a or 6b $ _____
10. Other (i.e., furniture). Do not include expenses of maintaining home (i.e., mortgage interest, real estate taxes, and insurance). $ _____
11. Add lines 6a or 6b through 10 $ _____
12. Total number of persons who lived in household _____

Yearly expenses for your same-sex domestic partner

13. Divide line 11 by line 12 to determine each person's part of household expenses

    $ _____ (line 11) ÷ _____ (line 12) = $ _____ (line 13)

14. Clothing $ _____
15. Education $ _____
16. Medical and dental $ _____
17. Travel and recreation $ _____
18. Other (please specify) _____ $ _____
    _____ $ _____
    _____ $ _____
19. Total amount for your same-sex domestic partner's yearly support (Add lines 13 through 18) $ _____

20. Amount your same-sex domestic partner provided for his or her own support

Line 3	$ _____
Line 6b (include if your same-sex domestic partner owned the home)	$ _____
Add lines 3 and 6b, if each are applicable	$ _____ line 20

21. Amount that others added to your same-sex domestic partner's support. Include amounts provided by state, local, and other welfare societies or agencies. Do not include any amounts included on line 2. $ _____

22. Amount **you** provided for your same-sex domestic partner's support:

$ _____ (line 20) + $ _____ (line 21) - $ _____ (line 19) = $ _____ (line 22)

23. 50% of line 19 $ _____

If line 22 is more than line 23, your same-sex domestic partner qualifies as an IRC Section 152 dependent. Check "Yes" on the *Declaration of Tax Status* form.

If line 22 is **not** more than line 23, check "No" on the *Declaration of Tax Status* form. As a result, the amount that **the state will contribute** (shown below) for your qualified same-sex domestic partner and/or child(ren) is considered taxable by the IRS. The tables below show the amount that will be added to your total gross income and calculated into your withholding tax; this will be reflected on your pay stub, as well as your *Wage and Tax Statement* (your W-2). The monthly amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Active employees

	2004 State Contribution for Medical and Dental Coverage for:		
Medical Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All medical plans	$315	$253	$568

	2004 State Contribution for Dental Coverage (Without Medical Coverage) for:		
Dental Plan	**Partner**	**Partner's Child(ren)**	**Partner and Child(ren)**
All dental plans	$35	$35	$70

Retirees who cover a Medicare-enrolled SSDP will receive a 1099 form from HCA reflecting the State's contribution toward the SSDP's medical coverage for the year. The amounts below are rounded to the nearest dollar, consistent with IRS tax reporting.

Medicare retirees

Medical Plan	**2004 State Contribution for Medical Coverage for Partner**
Premera BC Medicare Supplement Plan E	$49
Kaiser Permanente	$100
All other medical plans	$102

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm information before making decisions.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.